Introduction

Chairman Rockefeller, Ranking Member Grassley and members of the subcommittee, I would like to thank this committee for inviting me to discuss the clinical aspects of good pain management and more importantly tell you about the applied solutions we have put in place at the University of Washington (UW) and in the State of WA. I am pleased to report the very promising preliminary results of these interventions, especially in the Medicare, Medicaid population.

There is virtually no evidence to support that high dose opioids relieve pain or improve function, or is safe.

It is unfortunate that in the English language we use the same word for pain as a symptom and Pain as a disease. Pain as a symptom is a by-product of a disease. Take care of the disease and the pain goes away. However when pain becomes the disease, when there is nothing broken to fix, infection to cure or to tumor to operate upon, treating pain as a symptom doesn't work. It actually makes things worse.

This is why we are seeing so much harm with prescription pain drugs.

There is growing evidence that shows that opioid treatment over 90 days is usually a commitment for life.

To treat pain as a disease, a treatment plan may *sometimes* include opioids, but *always* includes listening to the patient, determining what is interfering with his or her life, define functional goals and individually tailor a variety of medical, exercise, mind-body treatments and healthy life choices.

Opioid related death crisis is in essence a 'reimbursement crisis', since medications are the best reimbursed pain treatment in the safety net population.

A large volume of material has been recently published in the GAO, IOM, ONDCP and DoD/VA Pain Task Force reports, and there are a few points worth remembering. First there is virtually no evidence that high dose opioids relieve pain or improve function in chronic non-cancer pain. Second, there is growing evidence that shows that opioid treatment over 90 days is usually a commitment for life. Third, it is usually the most vulnerable, sickest and disadvantaged patients (Medicare, Medicaid, Veterans) who receive the most opioids, oftentimes because that is what their healthcare professional knows and what the insurance will cover (Bradley et al, 2011; Seal et al, 2012).

Opioids are potent and reliable pain relievers, but they are not panacea. They do not work for all pain, or for all patients. There are no 'good' or 'bad' opioids. There are only opioids that are prescribed appropriately, safely or not. Although the challenges of balancing benefits and harm of opioids exist, they are not different then other treatments in medical practice. Responsible opioid prescribing relies on subtle changes in attitude, relatively simple changes to policy and a willingness to examine one's approach to opioids. (Scott Fishman: 'Responsible Opioid Prescribing', Federation of State Medical Boards, 2nd edition, 2012, Waterford Life Sciences).

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University of Washington (UW) and WA State efforts to prevent prescription opioid-related deaths include:

Measuring pain, mood and function at each clinical encounter is key to understand patients and the effectiveness of treatments

1. Since November 2008, the UW Pain center has been using a patient screening and assessment tool during **every** clinical encounter. This tool allows patients to describe how pain impacts key domains of their lives, including pain interference to essential activities, status of physical functioning, emotional well-being, satisfaction, and potential risk for prescription opioid abuse and misuse. Combined with routine urine drug tests (Laffer, 2011) this model of measurement-based care informs clinicians about important patient characteristics, treatment progress, and the overall the patients visit (Cahana, 2011). It also permits decision makers to identify exceptional outcomes, efficiencies, and needed resources for expansion of services to provide effective and efficient outcomes.

Urine drug testing is necessary for assessing the risk of opioid therapy and monitoring patient's adherence to treatment

Opioid related deaths have decreased up to 65% in counties using video-mentoring technology (ECHO)

2. In order to increase the availability of specialty care we initiated twice a week a 90-minute TelePain provider-to-provider consultation. This service called **ECHO** (Extension for Community health Outcomes), was developed in the University of New Mexico and is designed to improve access to specialty care for underserved populations with complex health problems. It uses video-conferencing technology to train primary care providers to treat complex diseases, and has been shown to be as effective and safe as specialty care (Arora et al, 2011).

Since March 2011 we have given 2240 training hours to 1500 health professionals from 76 locations, with an average of 40 providers dialing in at each session. We have documented an improved sense of knowledge of opioid prescribing among our primary care providers treating patients with chronic pain and an even higher decrease in mortality rate in counties receiving education (up to 65%) compared to the state average (35%) (Merril, under revision).

Tapering patients through a second opinion opioid review consultation improves patient outcome and is cost effective

3. Since 2010 we provide a second opinion consultation for Medicare/Medicaid beneficiaries receiving high doses (over 1000 mg MED) of opioids, following the model of the second-opinion consultation developed for children treated with antipsychotics, which was shown to improve patient outcome and cost-effective (Thompson, 2009).

Most pain patients are seen by primary care providers or in the emergency room

4. Look over the expert shoulder (LOES) is a postgraduate educational program, allowing advanced training and certification in pain community practice settings. LOES-trained "Pain Champions" are expected to serve as educators, leaders, and resources in communities where specialty pain clinics are unavailable or inconvenient due to excessive distance.

Targeted education for Top prescribers engages providers to become 'Pain Champions'

Emergency Department Information Exchange Program has decreased unnecessary ED visits by 56%

5. Also in use is an Emergency Department Information Exchange reduces the chance of patients obtaining multiple prescriptions from more than one provider. Providers have access to information on previous visits and prescriptions and this decreases the possibility for patients to obtain non-prescribed opioids that may be misused or abused. For patients denied an unscheduled prescription refill request at the emergency department (ED), EDIE facilitates communication between the ED and patients' primary care provider (PCP), alerting the PCP to make a decision on subsequent interventions that may be warranted. In the Spokane area the use of EDIE has decreased unnecessary Emergency room visits by 56%.

The Medicaid 'Lock in' program with a single provider, single ED, single hospital program has improved patient safety

6. Since 2012 a Prescription Monitoring Program (**PMP**) has been in place at UW and we are currently establishing an on-line, real-time controlled substance reporting system to track the prescription and dispensing of controlled substances. This requires practitioners to review a patient's prescription history on the system *prior* to prescribing and require reporting the prescription *at the time* of issuance. It also requires pharmacists to review the system to confirm the person presenting such a prescription possesses a legitimate prescription *prior* to dispensing and requires pharmacists to report dispensation of such prescriptions *at the time* the drug is dispensed.

"I never knew these pain patients were so nice and so grateful and I can't believe I nearly missed this course"…

4th year medical student after a course in Pain Medicine

AHRQ and CDC have endorsed the AMDG guidelines

7. State Guidelines:

In response to the emerging epidemic of deaths from prescription opioids reported from Washington State (WA) (Franklin et al., 2005) and nationally (Paulozzi et al., 2006), the Agency Medical Director's Group (AMDG), representing all of the WA public payers (Medicaid, workers' compensation, corrections, health, public employees), convened in 2006 an advisory group of clinical and academic pain experts. The group developed an Interagency Guideline on Opioid Dosing, which was then implemented as a web-based educational pilot in April 2007. The hallmark of this Guideline, in addition to widely agreed-upon best practices, was the inclusion of a ''yellow-flag'' warning opioid dose threshold of 120 mg/day morphine-equivalent dose (MED).

The risks of dying from opioids increases 9 fold at doses over 120 mg morphine equivalent a day.

The Guideline recommended that prescribing providers obtain consultation from a pain medicine expert for patients with chronic non-cancer pain (CNCP) receiving opioid doses greater than 120 mg/day MED, whose pain and function had not substantially improved during opioid treatment, before continuing to prescribe daily doses above 120 mg MED. This threshold is based on epidemiological data showing a significant relationship between opioid-related morbidity and mortality (Braden et al., 2010; Dunn et al., 2010; Bohnert et al., 2011; Gomes et al., 2011).

Implementation of AMDG guidelines have resulted in 50% and 35% decrease in deaths from opioids between 2009-2010 in the Worker's compensation and Medicare/ Medicaid beneficiaries

The dosing guidance in the WA Guideline was specifically directed to address the probable mortality risks of chronic high-dose opioid therapy that was not providing clear benefit and included a web-based opioid dosing calculator that physicians could use to quickly to calculate the total daily MED from all opioid medications.

Since initial implementation of the AMDG guideline, we report 50% and 35% decreases in opioid mortality in the WA workers' compensation population and the Medicare/Medicaid population respectively.

Summary

Over-reliance on opioids (but also diagnotic tests, procedures and surgery) is poor pain management. It is a result of a combination of:

1. **Insufficient** provider training and patient education
2. Lack of accessible real-time **patient reported outcome data** for the prescriber, to indicate whether prescriptions or other treatments are effective and safe
3. Presence of strong financial incentives to **over-prescribe**, over-test and over 'proceduralize' pain complaints, especially in the Medicare and Medicaid population.

A comprehensive strategy to decrease opioid-related deaths should include:

1. Best clinical practice guidelines

2. Prescription Monitoring, Take Back and Emergency Department Information Exchange Programs

3. Tele-Health and video-mentoring solutions to improve access to specialty care

4. Incent providers to assess, coordinate care and measure pain, mood and function at every clinical encounter

For better health, better health care and reduced costs I suggest:

1. **Incent** providers that follow best practice guidelines, spend time to assess patients, coordinate care and **measure** pain, mood and function at every clinical encounter
2. **Pay** for video-mentoring (ECHO), behavioral counseling, integrative medicine and **decrease payments** to treatments of low or unproven value (such as repeat tests, high dose opioids, repeat procedures and surgery).
3. Fund prescription monitoring programs, Take Back programs and Emergency Department Information Exchange programs
4. Fund undergraduate and postgraduate **training** that will improve competence in pain medicine both for primary care and for specialists (Dubois, 2010)

The ultimate answer to lethal and expensive pain treatments is to 'demedicalize' pain as much as possible. In general the more widespread the pain is, the less medically intensive the pain treatment should be.

(Sullivan, 2012)